



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586

Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Strattera Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Strattera (atomoxetine). Additional information about which drugs require PA can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

Medication information

Strattera request (Check one or all that apply.) <input type="checkbox"/> Strattera 10 mg <input type="checkbox"/> Strattera 18 mg <input type="checkbox"/> Strattera 25 mg <input type="checkbox"/> Strattera 40 mg <input type="checkbox"/> Strattera 60 mg <input type="checkbox"/> Strattera 80 mg <input type="checkbox"/> Strattera 100 mg	Dose, frequency, and duration Note: The manufacturer recommends an initial dose of 0.5 mg/kg/day for children and adolescents weighing < 70 kg with a target dose of 1.2 mg/kg/day. The maximum dose is 1.4 mg/kg/day or 100 mg, whichever is lower. In patients weighing more than 70 kg, the recommended initial dose is 40 mg daily with a targeted dose up to 80 mg. Daily dose of Strattera should not exceed 100 mg. Indication (Check one or all that apply.) <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) <input type="checkbox"/> Other (Explain.) _____	Drug NDC (if known) or service code
Is member under the care of a psychiatrist or behavioral specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of psychiatrist or behavioral specialist _____		
Telephone no.: _____ Date of last visit: _____		
Please list all medications currently prescribed for this member for this condition. _____ _____		
Please describe your new treatment plan for managing this member's condition, including discontinuation of any medications as a result of the addition of Strattera. _____ _____		

Medication information (cont.)

Has member tried other medications in the methylphenidate class (i.e., Concerta, Focalin, Metadate, Methylin, or Ritalin) to treat this condition? ☐ Yes. Complete box A. ☐ No. Explain why not. _____

A. Drug name	Dates of use	Dose and frequency
Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____		

Has member tried other medications in the amphetamine/dextroamphetamine class (i.e., Adderall or Dexedrine) to treat this condition? ☐ Yes. Complete box B. ☐ No. Explain why not. _____

B. Drug name	Dates of use	Dose and frequency
Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____		

Has member tried other non-stimulant medications to treat this condition?

☐ Yes. Complete box C. ☐ No. Explain why not. _____

C. Drug name	Dates of use	Dose and frequency
Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____		

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ()	Fax no. ()
Address		City	State Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State Zip
E-mail address			Telephone no. ()	Fax no. ()

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date